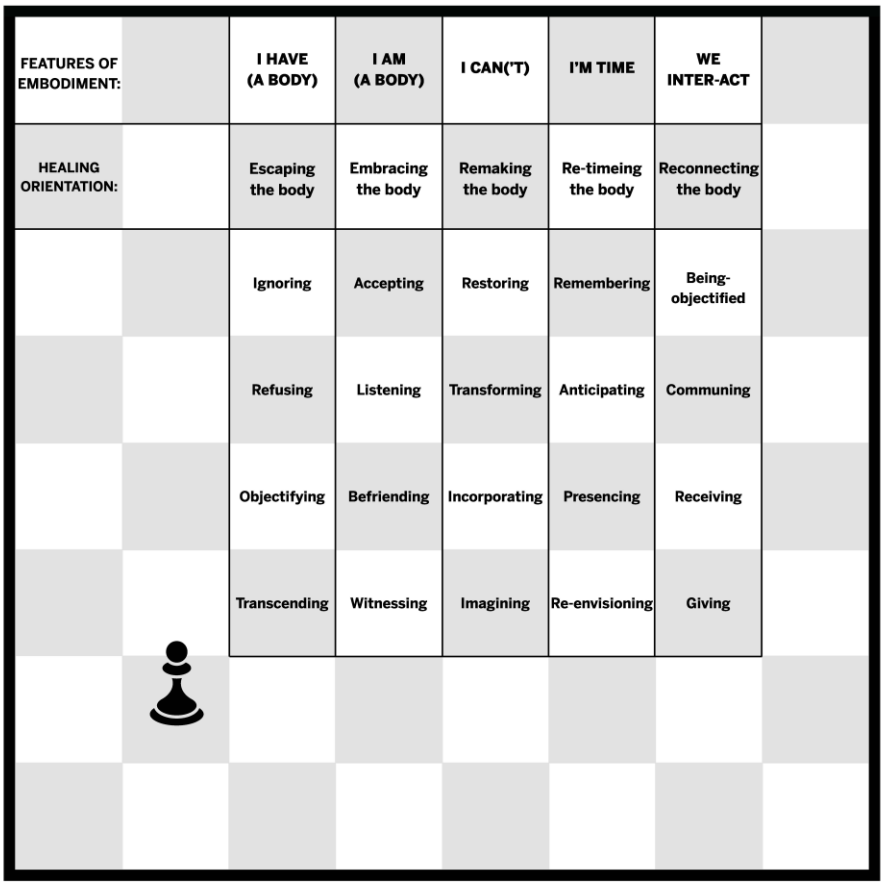
RIVISTA INTERNAZIONALE DI FILOSOFIA E PSICOLOGIA
DOI: 10.4453/rifp.2024.0011
ISSN 2039-4667; E-ISSN 2239-2629
Vol. 15 (2024), n. 2, pp. 95-103

SYMPOSIUM

The healing body: Creative responses to illness, aging, and affliction. A précis

Drew Leder[(α)]

Ricevuto: 29 novembre 2023; accettato: 11 dicembre 2023



FEATURES OF EMBODIMENT:	I HAVE (A BODY)	I AM (A BODY)	I CAN('T)	I'M TIME	WE INTER-ACT
HEALING ORIENTATION:	Escaping the body	Embracing the body	Remaking the body	Re-timeing the body	Reconnecting the body
	Ignoring	Accepting	Restoring	Remembering	Being-objectified
	Refusing	Listening	Transforming	Anticipating	Communing
	Objectifying	Befriending	Incorporating	Presencing	Receiving
	Transcending	Witnessing	Imagining	Re-envisioning	Giving

[(α)]Philosophy Department, Loyola University Maryland, 4501 N. Charles Street – 21210 Baltimore MD (USA)
E-mail: dleder@loyola.edu

1 Introduction: The chessboard of healing

IN HEALTH WE MOVE THROUGH our world with relative ease, employing our bodily capacities to further our goals, embedded with others in a shared lifeworld. But when faced with a serious disease or incapacity, this structure can disintegrate in multiple ways (LEDER & JACOBSON 2014; SVENAEUS 2011). One's very own body now manifests as an intruder (NANCY 2002), something strange (SLATMAN 2014), threatening to overturn our plans (SVENAEUS 2015). Lived-time, which was a repository of past experience, and a launchpad for futural goals, may now contract into the aversive, yet inescapable, *present* of pain and dysfunction (LEDER 2016). Space similarly collapses inward as the sick person is confined by bodily incapacity, and perhaps the accompanying need for bed-rest or hospitalization (VAN DEN BERG 1966).

This all correlates with a multifaceted rupture between self and others. As others proceed with their usual life-routines the sick person can only watch from the sidelines. Even to try to communicate inner sensations, such as pain, is notably difficult in language. Nor will others always be empathically present; serious *disease* may indeed them *uneasy*, calling attention to our common vulnerability. Also disrupted by serious illness is one's own sense of stable identity. A sudden heart attack or cancer diagnosis may upend one's life-narrative (BURY 1982; EGNEW 2018), and even the sense of dwelling in a meaningful or just universe (HAWKINS 1999).

There is an extensive literature on this phenomenology of illness, but less so on *healing* – what it means, and how it takes place. This is the central question that organizes my book, *The healing body: Creative responses to illness, aging, and affliction* (LEDER 2024). To "heal" (from the same root as the word "whole") involves a re-integration, albeit often in a new form, of all that illness dis-integrated. The book attempts to catalogue and appreciate the healing strategies *employed by ill persons themselves*, not the efficacy or lack thereof, of clinical interventions. The "patient" – a word drawn from the same root as the word "passive" – is very much an *agent* whose coping strategies deserve study and respect.

In personal terms, this book also constitutes the last in a kind of trilogy completed over three decades. In the first book, *The absent body* (1990), I used phenomenological methods to examine the many ways in which the body disappears from experience or surfaces particularly when problematic. I suggest that this is an experiential underpinning for the Cartesian dualism which separates the essential self from its body. Then, in *The distressed body* (2016), I investigated the experience of chronic pain, illness, and incarceration, as well as how these are dealt with by the medical and carceral systems (hint: often not well). This newest book, *The healing body*, is more a celebration of human resilience in the face of affliction. Of course, there is an extensive literature in medical anthropology and sociology on modes of resilient adaptation to illness. However, different studies utilize different patient populations, methodologies, and classificatory systems, and therefore are difficult to conceptually integrate (one overview article examines 106 in all – see WHITE *et alii* 2018).

Instead, I try to build upon fundamental structures of lived embodiment that have been examined by Husserl, Merleau-Ponty, and other 20th and 21st century phenomenologists. In the first half of my book, I suggest that these give rise to a kind of "chessboard" of possible healing moves that one can make in the face of bodily breakdown. I do not place these strategies of healing in any kind of a hierarchy of better and worse, more or less sophisticated. Each one brings with it benefits, as well as a "shadow-side" if used excessively or inappropriately. My sense is that different strategies will prove more or less effective at different times depending on personality types, the nature and progression of illness, and one's shifting life situation. In addition to making a contribution to the philosophy of medicine and embodiment, my goal is to help individuals analyze the healing strategies they currently use and others that remain available on what I picture as a "chessboard of healing". Often the more strategies we have at our disposal the more flexible and effective we can be in responding to afflictions which themselves are ever-changing.

I do not claim this chessboard of healing is universal – that is, transcultural and transhistorical. Embodied experience will be experienced and responded to differently in different social settings, including those unfortunately warped by racism, sexism, ageism, ableism, homophobia, and other modes of dehumanization. Nonetheless, the human body does have built into it a variety of features (sensitive skin, eyes that see, visceral depths, susceptibility to gravity, the capacity for pain, and so on) that serve to constrain and vector the uses and interpretations we make of embodiment.

2 Escaping and embracing the body

As a first example, phenomenology has examined how persons often vacillate between the sense that "*I am*" my body – its sensorimotor powers *my own*, such that I would say *I am* typing these words and *you are* reading them – and the sense that *"I have"* a body, an object in the world. (SLATMAN 2014, pp. 53-83)

Interestingly enough, it could be said that *both* sides of this self-body ambiguity are highlighted by illness. Weakened and nauseated by a bad cold, I am reminded how much *I am* my body insofar as my physicality is central and inescapable. We do not

usually say "my stomach has a flu", but "*I* have a flu", that is *my* condition. At the same time, this body is revealed as something alien – something *I have* but which stands apart from my intentions, even actively undermining them. I suggest that both sides of this *I am/I have* dichotomy open up strategies for healing in the face of bodily breakdown.

First, I focus on the body which *I have*, but which need not *have me*. It turns out the very alienation from body that characterizes illness also opens up possibility-spaces for healing. I examine four variations of such "escaping" the body, as I do for each of five different features of embodiment, creating a five-by-four matrix, the so-called "chessboard of healing" pictured above.

First, we can simply *ignore* symptomatology and limitation. This may seem like a primitive healing strategy, one which can shade into maladaptive denial and risk actions that aggravate the condition. As mentioned, each healing strategy has limits and a shadow-side if applied inappropriately. However, *ignoring* the problematic body remains not only one of the most used, but often one of the most valuable of healing strategies. It can allow us to foreground and pursue our desired life, taking attention away from a potential source of limitation. Moreover, *ignoring* can actually lessen pain and dysfunction. Neuroscientific understandings, such as the "gate-control" model, and Melzack's somewhat more sophisticated "neuromatrix" theory, suggest that focusing on pain experience can "turn up the signal" on the central nervous system level, making pain more intense and chronic even when the peripheral stimulus is no longer present (MELZACK & WALL 1996; MELZACK & KATZ 2004). The converse is true as well: *ignoring* pain can block it from entering into conscious experience, even begin to rewire neural circuitry.

There are other ways we escape the tyranny of the ill body. We may simply *refuse* to be limited by incapacity, for example going forward with vacation plans, or our work and family duties. We can also *objectify* the dysfunctional body part. I was just discussing with a friend how he strategically depersonalizes his body. "It's just a knee", he said, and this distanced perspective allowed him to seek orthopedic help with his problematic joint, and prepared him for knee replacement. Finally, we can *transcend* our body, that is identifying our self more with our imagination, intellect, or spirit, pursuing activities uninhibited by bodily limits. For example, we may lose ourselves in reading fantasy literature; keep a sense of humor that allows us to "rise above our problems"; priorite loving relationships; or access spiritual perspectives and practices. Who am I, if not just this limited body? What value do I have beyond my productivity? What will remain after death?

Such are no longer theoretical questions but press in when one faces serious impairment or terminal illness, and many turn to *transcendence* for answers.

I then turn in the book to strategies of moving toward, *embracing,* the body rather than *escaping* it. Insofar as *I am* my body, and can feel like "*I am-with*" it in intimate and friendly relation, illness and impairment can induce me to move closer to the body at a troubled time. Again, I examine four variations on this theme. The first is *accepting* one's condition, the opposite of the earlier discussed *ignoring* and *refusing*. If, for example, one has rheumatoid arthritis, accepting that this is the new state of affairs can remove the suffering that attends denial and emotional conflict, as well as opening up appropriate rehabilitative modes. This can go hand-in-hand with *listening* to the body, *befriending* it in compassionate alliance, and *witnessing* bodily states without undue resistance. In the words of Nietzsche (1954),

> [...] behind your thoughts and feelings, my brother, there stands a mighty ruler, an unknown sage – whose name is self. In your body he dwells; he is your body. There is more reason in your body than in your best wisdom. (pp. 146-147)

Nietzsche's point is deliberately countercultural. It has been customary in Western philosophy and theology to ascribe wisdom to the intellect or soul. This, as I discuss later in the book, could be called the "superior interior". The subvocalizations and internalized imagery that we associate with thought, rationality, and the immaterial soul, are valorized as the highest human functions. Contrasting with that is an "inferior interior" – the interoceptive awareness of our visceral body, including states of fatigue and energy, levels of hunger and hydration, the depth and quality of our breath, etc.

Our culture has done a poor job of preparing us to hear and value these signals, since the body is often viewed as mindless machine, or the source of troublesome hindrances and passions. With the goal of what Foucault characterizes "disciplining" the body (1979, pp. 135-308), a pervasive power-strategy used to enhance docility and efficiency in institutions such as schools, factories, prisons, and the army, one is taught to ignore or override many bodily messages – for example, putting in long hours of work despite fatigue, applying frequent doses of caffeine as needed.

Instead, the strategies that involve *embracing* the body allow for what I call "inside insights". That is, the inner-body offers up a wealth of information and requests that are valuable for our health. Here we can learn from cultures and traditions more focused on body awareness and cultivation than our own. For example, Buddhist *vipassana* meditation, which teaches careful, sustained attention to the

breath and other bodily sensations, has given rise to mindfulness protocols now popular in integrative medicine (KABAT-ZINN 2013). Then too, Chinese acupuncture and *qigong,* Hindu-derived *hatha yoga* poses and *pranayama* breath methods, are increasingly used in the West as health practices, as well as are many other body-therapies.

To pay greater attention to interoceptive messages – what kind of foods sit well, how much sleep and movement we need, what subtle symptoms of imbalance are manifesting that might lead to chronic problems – constitutes an ever-available resource in preventive medicine. Such inside insights are free; they demand no costly insurance premiums. These might forestall expensive and burdensome doctor visits, invasive laboratory studies, prescription drugs laden with side effects, emergency organ repairs and transplants which do not always work.

This is not to deny a shadow-side even to this seemingly positive turn within. Not all illnesses register interoceptively: one might miss symptom-free but perilous high blood pressure or a silently spreading cancer. We may also neglect to acknowledge and remedy environmental causes of disease. We have carcinogens in our food and water. Agricultural subsidies help assure a never-ending, inexpensive stream of unhealthy foods filled with corn syrup and fat. Productivity pressures, unemployment, racism, sexism, homophobia, poverty, unsafe conditions on our streets, or simply reading the daily news, can send blood pressure soaring. A shadow-side of a focus on inside insights is that it can seem to place the blame on the *individual* for health difficulties, distracting from the political reform needed to create a health-supportive world.

3 Ability and temporality: Remaking and retimeing the body

So far I have focused on healing strategies arising from our ambiguous *I have/I am* relation to our bodies. In the book I then turn to what Husserl and Merleau-Ponty referred to as the "*I can"* structure of bodily ability. For example, as dinnertime approaches, *I can* walk down the stairs, make dinner, sit down and watch TV, etc. The lifeworld I inhabit, even the house with its bathroom, kitchen, dining room, etc., are organized around all these things *I can* do. Of course, my biological potentialities also had to be developed through long social training. As a child, I laboriously learned to assume the upright posture and walk, to climb stairs, to spell out the alphabet, and so on. Over time these habits of perception and action become sedimented within my body. (MERLEAU-PONTY 2012, pp. 143-155) As such, we might coin a word such as "habitabilities", to express how our habitually cultivated abilities allow us to in-habit our lifeworld in a rich variety of ways. (MERLEAU-PONTY 2012, pp. 153-155).

Yet at times of corporeal dysfunction the way I inhabit body and world are inhibited. At such times I experience the body as characterized not only by the *I can,* but the *I can't*. Due to illness, injury, or the incapacities of old age, I may lose a number of abilities. It is something of a truism in the field of disability studies that we are but "temporarily abled", because of the transience and vulnerability of embodied life.

As temporality comes to the fore, I thus turn from "escaping" and "embracing" the body to "remaking" it consequent to breakdown. Again, I examine four variant approaches in this domain. One may attempt to *restore* functions from the past or, if this seems impossible, to *transform* one's patterns of bodily usage to make up for a lasting deficit. Often, rehabilitative efforts can shift between one or the other of these polarities, or combine elements of both. For example, after a serious leg injury one may seek to build up muscles to their previous strength, or one might compensate for a permanently weakened leg by a transformed pattern of gait or use of a walking stick.

In the latter case one is including in one's corporeal schema a supplemental element (the stick) that is extrinsic to the flesh-and-blood body, but now has becomes part of its ability-structure. I refer to this healing strategy as *incorporation.* One brings a tool or technology within the physical body, or the corporeal schema whereby we inhabit the world. In my own case, I use a flexible knee brace which, post-meniscal-surgery, steadies me on a long walk; a CPAP –continuous positive air pressure – machine for sleep apnea that helps "breathe" me through the night; a sacroiliac belt that supports my lower back when lifting; contact lenses for my severe astigmatisms as well as reading glasses when needed – I could go on. As Slatman (2014) writes,

> we may think of bodily aids and adjustments as exceptions to a "normal" situation, but it has actually become more normal to meet somebody with a prosthesis than without one (p. 58).

Of course, as with all healing strategies, *incorporating* has its shadow side. One might become over-reliant on an external technology (for example, a wheelchair) such that one underutilizes one's own abilities (to walk), hastening physical decline. Technologies can also be cumbersome and intrusive: many people never become comfortable wearing a CPAP mask throughout the night leading to compliance issues. Moreover, prostheses can malfunction, wear out, or simply be expensive and thus unevenly available to the public in ways dependent on income and insurance coverage.

If *incorporating* is nonetheless a key healing strategy whereby we "interiorize" an external object, *imagining* moves in the opposite direction: we

gradually "exteriorize" internal imagery designed to facilitate the body's healing potential. As Jill Bolte Taylor, a 37-year-old neuroanatomist, recounts her recovery from a devastating stroke:

> I am convinced that focusing on how it feels to perform specific tasks has helped me recover them more quickly. I had dreamed of skipping up steps every day since the stroke. I held the memory of what it felt like to race up the steps with abandon. By replaying this scene over and over in my mind, I kept that circuitry alive until I could get my body and mind coordinated enough to make it reality (TAYLOR 2009, p. 127).

As to the clinical value of *imagining*, we can look for confirmation not only from particular cases and studies, but the structure of medical research at large. The "gold-standard" double-blind study must control for the placebo effect in order to evaluate the efficacy of any new drug or surgery. That is, patients simply *imagining* they are receiving a beneficial treatment has itself so much healing power that this must be subtracted in order to determine if the treatment in question itself had any benefit.

The previous discussions on "remaking" the body highlight how the body is ever in flux. Not everything is fixable; coping well with illness and aging also means flowing successfully with change. In the book I speak not just of "chronic illness", but of "chronic healing". This term is meant to suggest a variety of meanings: that healing takes time; is an ongoing challenge as both the illness and our coping strategies may shift; and that "chronic healing" involves not only healing over time but the *healing of time itself* (*chronos*, in Greek).

I thus then turn to healing strategies that directly involve "retimeing" the body, that is changing our relation to past, present, and future, as well as to our ongoing narrative identity through time. For some, *remembering the past* can be a mode of healing. Robert Butler (1974) formulated what is now a widely accepted concept in gerontology, that "life-review" is a natural and potentially healthy part of aging. Even if the *I can* has shrunk with advancing age or incapacity, recalling all we once did may help one feel that one has lived a fulfilling life, made the most of opportunities, has few regrets. The strategy of *anticipating* represents the complementary opposite, focusing instead on hopes for the future. Many with an illness or injury look forward to a time when it will be fully diagnosed, better treated, or healed through the passage of time. This anticipatory hope may provide energy and patience for the often challenging nature of therapeutic and rehabilitative processes.

However, both *remembering* and *anticipating* have toxic side-effects if inappropriately used. *Remembering* may shade into a kind of painful "nostalgia", a word formed from the Greek roots, *nostos* or "homecoming", and *algia*, meaning "ache" or "pain" – that is, the ache of being far from home. One devalues the present *I can* if focused overly on what *I can't* do anymore. Similarly, *anticipations* of the future are not always positive – they can lead to fear-inducing catastrophizing – and even when optimistic can lead to devaluation of the present, along with a kind of temporal stasis. Minkowski refers to this disordered temporal mode as "expectation" (*attente*). Ordinarily we move purposefully toward a desired future. But when stuck in expectation, «we see the future come toward us and wait for that (expected) future to become present» (MINKOWSKI 1970, p. 87). Many a patient thus waits for the next specialist visit, treatment, or scientific breakthrough; this can be a set-up for neglecting to appreciate the here and now, and disappointment when the future breakthrough never arrives.

This brings us to the healing orientation I call *presencing*. Havi Carel (2014), at age 37, discovered she had *lymphangioleiomyomatosis* (LAM), a rare, progressive, and at the time, uniformly fatal pulmonary disease. She writes:

> Time did change for me. I began to take it much more seriously. I began to make a point of enjoying things thoroughly: memorizing sensations, views, moments. I wanted to feel that I am living life to the full in the present. That I *am* now. By focusing on the present I learned to discount the future, while it seemed to me that so many of my friends were doing the opposite [...] Yes, Really Bad Things could happen to me at any minute. But not now. And now is where reality is: liquid time solidified into a crystal drop of Now. I grasped that drop with both hands, clutching, savouring, enjoying (pp. 144-145).

It is not uncommon that aging, disability, even a fatal disease, is thus accepted as a gift: it may lead one to get priorities straight, focus on meaningful activities and loving relations, make the most of the precious present. Of course, one's life is not made up simply of disconnected regions of time (past, present future) but are organized into a meaningful whole guided by a narrative structure. Yet this narrative can be challenged by serious injury or illness (SVENAEUS 2011). Bury (1982) coined the term "biographical disruption" to describe how serious illnesses can upend or redirect our sense of time and identity.

This may trigger the healing modality I call *life-story revision*, Kevin Aho (2019), a vigorous young philosopher friend of mine, had an unexpected heart attack while cycling. He writes:

> Any meaningful identity that I could envision was now constrained by the illness. And I

> would have to work against the background of these constraints to create myself again. Again, this process of reopening the future has been gradual. I've had to slough off identities that no longer hold for me. The most obvious is letting go of the sense of myself as someone who is fit, athletic, and strong [...] But the heart attack cracked me open. I was suddenly overflowing, not just with anxiety but with love and compassion. I called my brothers weeping, shortly after the angioplasty, telling them how much I cared about them and how thankful I was to have them in my life. My girlfriend became my fiancée in the Intensive Care Unit after my blood clot [...] As I struggle with the limitations (of) my altered body, let go of a former self that is no longer livable, and work to refashion a new identity in the face of a precarious and restricted future, I am grateful for what the heart attack has taught me (pp. 197-200).

Of course, not all life-story revisions are this positive. One might feel one's existence is rendered meaningless by a harsh setback, or that one is being punished by God or the universe for some deficit. Often, one needs the help of a sensitive treater or friend to move beyond a toxic story filled with anger, guilt, or self-pity.

4 Intercorporeality: Reconnecting the body

This brings us to the import of intersubjectivity in the process of healing, and the importance of strategies that stress the "reconnecting" of bodies. So far I have referenced the embodied "I" (as in the *I am/have* a body, which is the foundation of the *I can*). Nonetheless to have a body is always truthfully to be part of a "We", deeply affiliated with others, not contingently, but as something that inhabits us from within. This interpenetration of bodies is there from the very start of life. Biologically, our body only came into being (in most cases) because two other bodies combined their passion and genetic material creating a form that then was developed within the mother's body. Afterwards the infant may feed directly from the mother's breasts or be cradled while given a bottle; body-to-body touch has also been shown to be an important part of early development for animal and human infants (ARDIEL *et alii* 2010). As we grow, we remain almost totally reliant on embodied assistance from parents, teachers, and other caregivers, as well as being socially trained in the skills and abilities relevant to our culture.

In the chapters focused on intersubjectivity, I start with what I call *being-objectified*: the body *I have* can be examined, diagnosed, treated by others, insofar as it is a material object. This healing strategy dominates our healthcare system. Cartesian medicine, focused on repairing the body-machine, has done much to cure or alleviate diseases and other modes of dysfunction. My wife and I sometimes count the number of times we would be dead or disabled but for the intervention of modern medicine.

However, the shadow-side of this objectification is also evident to most patients. Modern medicine can be expensive, inequitably distributed, replete with negative side-effects, and depersonalized. Just at the time one is most in need of human compassion to be thus treated as an object can intensify the modes of alienation and disruption the illness had begun. I suggest that in the best medicine, objectification is best contextualized by the "4 H's": it involves a *hermeneutic* blending of the perspectives of treater and patient; a *holistic* and *humanistic* perspective on embodied health that moves beyond the specialized focus on body-parts; and it seeks genuinely *helpful* interventions, avoiding inappropriate or excessive over-treatment.

However, the body is not just an object (*Körper*, in German) but a lived body (*Leib*), the root of our subjectivity. As such, complementary to *being-objectified* is the healing strategy I term intersubjective and intercorporeal *communing*. Illness can be very isolating yet it helps when we can *commune* with others who share the same disease. I examine support groups for those with Parkinson's, a disease associated with multiple neurological deficits affecting speech, facial appearance, gait, fine-motor abilities, etc. When meeting others with the same problems, it is helpful to feel less alone in one's body, and to know one's impairments will be met with understanding rather than stigmatization. Then too, many turn to empathic friends and loved ones for support. Even if they do not experience the same symptoms, their own experiences of suffering, and their own caring attitudes, make of our shared vulnerability a source of intimacy rather than isolation.

Finally, I turn to the dialectic of *receiving* and *giving*, the last spaces on the "chessboard of healing". Both have their shadow-sides. An ill or disabled person can become too reliant on receiving help from others. This can limit the reclaiming of one's own *I can*, and become abusive of the caregiver. Conversely, for the ill or aging person, *giving* beyond appropriate measure may bring stress and relapse as one tries to maintain previous standards of productivity and contribution.

Nonetheless, both *receiving* and *giving are* elements of deep healing. Despite our culture's emphasis on independence, the truth is we are interdependent with one another. At times of illness or old age it is appropriate that we *receive* assistance with life's tasks. I do the night-driving for my wife who has vision problems; she carries in the groceries that I can no longer lift post-back-surgery. Our bodies supplement one another in an intercorporeal system greater than its parts.

Often, for an older or disabled person it is difficult to learn to *receive* graciously in a culture that so values autonomy. Similarly, it can be challenging to discover how much one still has to *give* the world despite, or sometimes as a result, of one's bodily challenges. Yet both are a part of rediscovering the healing interdependence of embodied life, ever involving a dialectic of mutual assistance. Nor is this only a personal matter, but one of great social import. To provide financial assistance for those with disabilities; to work at making buildings wheelchair accessible; to give paid caregivers dignity and a living wage – these are examples of how a society values our embodied connectivity.

5 Embodied injustice: Prisoners and elders

However, not all bodies are in the same position: our culture values some and devalues others, creating a toxic hierarchy. In the second part of my book I thus turn from the general analysis of limitation and healing to the special challenges that face persons caught up in systems of "embodied injustice". I suggest that modes of discrimination – racism, sexism, homophobia, ageism, ableism, and the like – disrupt the corporeal schema in similar and destructive ways. This not only can be the cause of disease and premature death, but can actually mimic the phenomenological disintegrations characteristic of chronic illness.

Here I draw on accounts from Fanon and Yancy (racism), Warren and Young (sexism) and many others, to examine alterations in one's embodied experience that result from oppressive systems. One is trapped in kind of double-vision, experiencing the body from within, but also as an object diminished, devalued, distrusted by others. One is also caught in double-binds: for example, as a woman to be sexually active may lay one open to being called a "slut", but if inactive to be chided as a "tease" or characterized as "frigid". All of this inhibits the free and full exercise of the bodily *I can.*

Having spent many years volunteer-teaching in maximum security prisons (which in the U.S. disproportionately incarceraties Blacks and Latinos) I use prisons to illustrate embodied injustice, as Plato's *Republic* examine justice "writ large" in an imagined city. I examine ways in which long-term imprisonment mimics chronic illness; temporal flow is disrupted by the pronouncement of a time-sentence; spatial movement is constricted; one body is distrusted and surveilled; social relations are interrupted as one is exiled from one's community. I question whether imposing such a "socially-constructed illness" can possibly be healing for those imprisoned, or the larger society. Nonetheless I suggest how incarcerated person often employ the same kind of healing strategies as those dealing with chronic illness, to survive, perhaps even thrive, in a constricted world. In this time of global pandemic and disruption we all have much to learn from these "experts".

I also turn to the situation of elders, facing both limitations imposed by the aging body, and by a social ageism that fears, marginalizes, and mocks the old. I criticize the most popular models of what it is to age "successfully" – for example, to financially and medically forestall deficits associated with old age; indefinitely prolong midlife vigor and productivity; or enjoy in consumerist leisure the fruits of one's efforts. Each of these approaches has its benefits, but also its shadow side. These models seek to negate the negatives associated with old age, but fail to articulate what is truly positive, deep and meaningful for self and society, in later-life phases. I turn instead to archetypes drawn from different cultures and spiritual traditions of the wise and creative "elder".

6 The inside-out body: Non-dual perspectives

As the book progresses I thus gradually expand focus from individual strategies of healing to intersubjective modes of assistance, and to social phenomena such as embodied injustice, with a special focus on incarceration and aging. In the three chapters of the book's final section, I suggest how the lived body at all levels is "inside-out": that is profoundly interconnected with the universe as a whole.

I begin by suggesting how "interoception" – our awareness of the inner body – is profoundly shaped by cultural and personal models of the body, a kind of outside-in hermeneutical circle. Moreover, our visceral functioning sets the preconditions for, and helps shape, all our interactions with the outside world. I mentioned earlier how attending to "inside insights" can be essential to a healthy body and lifeworld.

I next turn to the *breath* as constituting a multi-dimensional hinge constituted by the lived body. For example, the breath ordinarily proceeds unconsciously but can be brought into conscious awareness at any moment. While ordinarily regulated in an involuntary fashion by the "autonomic" (self-ruling) nervous system, it can be altered voluntarily. Breathing also involves physical dualities; it can be initiated by chest muscles or diaphragm, flow through mouth or nose, even with a focus on the left or right nostrils. There are thus multiple patterns of breathing, which may preserve health, or undermine it as in the case of tight, rapid, shallow breathing often employed in the West. Then too, the breath links the inside and outside world as we receive and return gases in ways complementary with other life-forms. Finally, the breath, which enlivens material life, can also seem strangely immaterial. The Greek word *psyche*, and the Latin *anima* and *spiritus*, which could be translated as "soul" or "spirit", all derive from the word for breath. The

soul can thus be conceptualized as the living principle that animates a body, but also as "mind" or "spirit", potentially disembodied and eternal.

This leads us to the final book chapter taking on that question directly, entitled *The transparent body*. In it I go beyond the limits of phenomenology proper, toward ontological speculation (but so too did Heidegger and the later Merleau-Ponty), as well as deliberately pivoting to non-Western perspectives.

Many spiritual traditions claim that the "ultimate healing" is not only that which heals the body for a time, but rather that which *heals us from our identification with the body*, and the deep suffering that accompanies limitation, illness, aging, and death. I turn as an example to teachings and practices I have long engaged with associated with Advaita (non-dualist) Vedanta. Herein *Atman*, the true self, is asserted to be one with *Brahman*, the divine energy underlying the universe. Putting aside the ancient Indian cultural and religious context of such teachings, I focus on a "direct path" version taught by Ramana Maharshi and others which has a phenomenological bent. In encouraging dis-identification with the body it seems directly opposed to the Merleau-Pontian focus on embodiment. Yet I also find that points of convergence and possibilities for mutual supplementation linking these perspectives.

In direct path teachings, as in Descartes' *Meditations* (2017), one begins by becoming aware of awareness itself. Upon investigation one finds a unified field. One can discover this experientially: allow attention to float between internal bodily sensations and more abstract thoughts; then between these and a birdsong or street noise. Never does one encounter a hard border between "body" and "mind", "inside" and "outside", "self" and "other" as consciousness floats freely. These apparent divisions are culturally conditioned interpretations. While it is true that my embodied perspective on the world differs from yours, it is also true that the fundamental structure of our consciousness has shared attributes. We each call ourselves "I". We each inhabit the "now" – no one has ever spent even a moment in the past or future. All also unfolds in the "here" of aware presence, not somewhere else. Though "now" and "here" are conventionally viewed as bits of time and space, an examination of consciousness reveals – as it did for Kant – that time and space actually appear as organizing principles *within awareness*.

As such, awareness itself, or "Awareness" (I will capitalize it rather than invoking religious notions like God or *Brahman*) is not some defined object with finite boundaries – hence we might call it "infinite". "Now", as experienced, is not a fleeting moment of clock-time, but the field of ever-presence within which we experience temporal change. Hence we might also refer to Awareness as "eternal", not in the sense of lasting a very long time, but as fundamentally beyond-time. This suggests a phenomenological reading of the Upanishadic notion that *Atman* is *Brahman*, the Self infinite and eternal. Awareness would then be rooted in the transpersonal even if incarnated through the lived body's personalized structure of abilities and perceptions.

As illustration Advaitic teachings take seriously the phenomenology of the dream state, as did Descartes at the beginning of the *Meditations*. When asleep I believe in a multiplicity of objects arrayed in time and space, and the separation of self and others. Only when I awaken do I realize this was all the product of a singular consciousness. Nonetheless the dreamer did need to localize through the perspective of a particular dream-body in order for this world to manifest. Similarly, the lived body may be akin to such a dream-body; it is very real from our worldly perspective (don't step in front of a truck!) and yet perhaps not the ultimate reality. Just as space is localized by the construction of houses, walls, rooms, without ever ceasing to be part of a unified space, so may transpersonal Awareness localize in personal lived bodies. From this perspective, illness, aging, and death are not ultimately our destruction, just as the tearing down of a house does not ultimately destroy space. In Buddhism it is said in that we do not die insofar *we were never born to begin with*: that is, the separate self was ever and always a fictional construct.

However, it is one thing to entertain such beliefs, another thing to re-condition the body-mind in such a way that one has *realization* of this qua liberatory practice. At the end of the book I share experiences of what I term the "transparent body" – that is, the body no longer experienced as heavy, limited, isolating, but rather as light, free, connected to the world in such a way that the division between "inside" and "outside" begin to fall away.

I also suggest that this is not only a mode of healing *from* the body conceived and experienced in limiting ways, but can also be valuable in the healing *of* the physical body. I give the example of a *qigong* breathing practice I used which dramatically alleviated the pain of my peripheral neuropathy forestalling the need for a third surgery. Viewing my body as transparent to and interconnected with the natural world, I could breathe in to my injured nerve the stability of the earth; the openness of the sky; the vitality of the trees; the fluidity of the stream along which I walked – all these are permutations of "*qi*" well recognized in Chinese culture. Somewhat to my surprise, pain relief was quick, thorough and lasting.

I seek not to claim that this or any practice will heal all ills. Siddhartha Gautama, according to legend, was shielded from an awareness of human suffering by his solicitous father until one day he witnessed a sick man, an old man, and a corpse.

This hastens him on the quest that led him to become the Buddha, the awakened one. Indeed illness, old age, and death are a corollary of embodied life that challenges us all. In *The healing body* I explore the many ways in which people personally, and perhaps transpersonally, find wholeness even at the heart of affliction.

Literature

AHO, K. (2019). *Notes from a heart attack. A phenomenology of an altered body*. In: E. DAHL, C. FALKE, T.E. ERIKSEN (eds.), *Phenomenology of the broken body*, Routledge, London/New York, pp. 188-201.

ARDIEL, E.L., RANKIN, C.H. (2010). *The importance of touch in development*. In: «Paediatrics & Child Health», vol. XV, n. 3, pp. 153-156.

BURY, M. (1982). *Chronic illness as biographical disruption*. In: «Sociology of Health and Illness», vol. IV, n. 2, pp. 167-182.

BUTLER, R.N. (1974). *Successful aging and the role of the life review*. In: «Journal of the American Geriatrics Society», vol. XXII, n. 12, pp. 29-535.

CAREL, H. (2014). *Illness: The cry of the flesh*, Routledge, London/New York.

DESCARTES, R. (2017). *Meditation on first philosophy. With selections of the objections and relies*, translated by J. COTTINGHAM, Cambridge University Press, Cambridge (Original edition: *Meditationes de prima philosophia*, Soly, Paris 1641).

EGNEW, T.R.A. (2018). *Narrative approach to healing chronic illness*. In: «Annals of Family Medicine», vol. XVI, n. 2, pp. 160-165.

FOUCAULT, M. (1979) *Discipline and punish: The birth of the prison*, translated by A. SHERIDAN, Vintage Books, New York (Original edition: *Surveiller et punir. Naissance de la prison*, Gallimard, Paris 1975).

HAWKINS, A.H. (1999). *Reconstructing illness: Studies in pathography*, Purdue University Press, West Lafayette (IN).

KABAT-ZINN, J. (2013). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*, Bantam, New York.

LEDER, D. (1990). *The absent body*, University of Chicago Press, Chicago.

LEDER, D. (2016). *The distressed body: Rethinking illness, imprisonment, and healing*, University of Chicago Press, Chicago.

LEDER, D. (2024). *The healing body: Creative responses to illness, aging, and affliction*, Northwestern University Press, Evanston (IL).

LEDER, D., JACOBSON, K. (2014). *The experience of health and illness*. In: B. JENNINGS (ed.), *The encyclopedia of bioethics*, vol. III, pp. 1434-1443, 4th edition.

MELZACK, R., KATZ, J. (2004). *The gate control theory: Reaching for the brain*. In: T. HADJISTAVROPOULOS, K.D. CRAIG (eds.), *Pain: Psychological perspectives*, Lawrence Herlbaum, Mahwah (NJ), pp. 13-34.

MELZACK, R., WALL, P.D. (1996). *The challenge of pain*, Penguin, London.

MERLEAU-PONTY, M. (2012). *Phenomenology of perception*, translated by D.A. LANDES, Routledge, London (Original edition: *Phénoménologie de la perception*, Gallimard, Paris 1945).

MINKOWSKI, E. (1970). *Lived time: Phenomenological and psychopathological studies*, translated by N. METZEL, Northwestern University Press, Evanston (IL) (Original edition: *Le temps vécu: etude phénoménologiques et psychopathologiques*, Delachaux & Niestlé, Paris 1933).

NANCY, J.-L. (2002). *L'intrus*, translated by S. HANSON. In: «New Centennial Review», vol. II, n. 3, pp. 1-14.

NIETZSCHE, F. (1954). *Thus spoke Zarathustra*. In: W. KAUFMAN (ed.), *The portable Nietzsche*, Viking, New York, pp. 103-439 (Original edition: *Also sprach Zarathustra. Ein Buch für alle und keine*, Schmeitzner, Chemnitz 1889).

SLATMAN, J. (2014). *My strange body: Philosophical reflections on identity and medical interventions*, Amsterdam University Press, Amsterdam.

SVENAEUS, F. (2011). *Illness as unhomelike being-in-the-world: Heidegger and the phenomenology of medicine*. In: «Medicine, Health Care and Philosophy», vol. XIV, n. 3, pp. 333-343.

SVENAEUS, F. (2015) *The phenomenology of chronic pain: Embodiment and alienation*. In: «Continental Philosophy Review», vol. XLVIII, n. 2, pp. 107-122.

TAYLOR, J.B. (2009). *My stroke of insight: A brain scientist's personal journey*, Penguin, New York.

VAN DEN BERG, J.H. (1966). *The psychology of the sickbed*, Duquesne University Press, Pittsburgh (PA).

WHITE, K., ISSAC, M.S.M., KAMOUN, C., LEYGUES, J., COHN, S. (2018). *The THRIVE model: A framework and review of internal and external predictors of coping with chronic illness*. In: «Health Psychology Open», vol. V, n. 2, published online August 21 – doi: 10.1177/2055102918793552.